



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE METHODIST HOSPITAL
PO BOX 1866
FORT WORTH TX 76101

Respondent Name

LUMBERMENS MUTUAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-08-1983-01

MFDR Date Received

November 20, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for Increased Reimbursement: "STOP LOSS APPIES"

Amount in Dispute: \$108,453.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "a review of the documents contained within the DWC-60 reveals only the UB-92 and an itemization. The Requestor included not a single medical record to document exactly what went on during the patient's in-patient stay. The Requestor provides nothing which would demonstrate the nature of the services performed, the need for those services, or the actual performance of those services. Nothing further is owed the Requestor at this time beyond the per diem rates for the dates-of-service at issue in this dispute. . . . As the minimum Stop-Loss Exception threshold was not met, and as the Requestor failed to demonstrate the surgery was unusually costly or extensive, it has failed to meet the two-pronged Stop-Loss criteria and merits no additional monies."

Response Submitted by: Hanna & Plaut LLP, Littlefield Building, 106 East 6th Street, Suite 600, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
June 15, 2007 to August 2, 2007	Inpatient Services	\$108,453.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). Beech Street
 - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. \$0.00
 - 857-999 – PROCEDURE INCLUDED IN ANOTHER CODE BILLED ON SAME DATE OF SERVICE \$0.00
 - 873 – REIMBURSEMENT NOT RECOMMENDED; SERVICE(S), ITEM(S) NOT MEDICALLY NECESSARY FOR REMEDIAL TREATMENT OF THE WORK RELATED INJURY/ILLNESS \$0.00
 - 885-999 – REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
 - \$0.00
 - \$4,567.00
 - \$41,760.00
 - 900 – BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
 - 975-640 – NURSE REVIEW IN-PATIENT HOSPITAL/FACILITY/SUPPLY HOUSE
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 981 – REVIEWED BY MEDICAL DIRECTOR.
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - \$0.00
 - \$4,567.00
 - \$41,760.00
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier denied disputed rehabilitation services billed under revenue code 118 with reason codes 50 – “These are non-covered services because this is not deemed a 'medical necessity' by the payer. \$0.00” and 873 – “REIMBURSEMENT NOT RECOMMENDED; SERVICE(S), ITEM(S) NOT MEDICALLY NECESSARY FOR REMEDIAL TREATMENT OF THE WORK RELATED INJURY/ILLNESS \$0.00.” 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee for health care determined to be medically necessary and appropriate for treatment of that employee’s compensable injury. §133.305(b) requires that “If a dispute regarding . . . medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding . . . medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.” The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity with regard to the disputed rehabilitation services billed under revenue code 118. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution. The Division concludes that the requestor has failed to support that the rehabilitation services billed under revenue code 118 are eligible for medical fee dispute resolution. Therefore, these services will not be considered in this review.
2. The insurance carrier reduced payment for disputed services with reason code 45 – “Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). Beech Street.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The above reason code is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
3. This dispute relates to rehabilitative inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(a)(2), effective August 1, 1997, 22 *Texas Register* 6264, which states, in pertinent part, that “rehabilitative inpatient admissions are not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline on these specific types of admissions.” The applicable rule for determining reimbursement is therefore 28 Texas Administrative Code §134.1, which provides for fair and reasonable reimbursement in the absence of an applicable fee guideline.
4. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d), which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures

that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”

5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 6. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
 7. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “a description of the health care for which payment is in dispute.” Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
 8. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
 9. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that “STOP LOSS APPIES.”
 - The requestor did not demonstrate or provide documentation to support that the stop-loss methodology, as found in the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401(c)(6), is applicable to the services in dispute.
 - As noted above, the Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute, as rehabilitative inpatient admissions are not covered by the guideline, per §134.401(a)(2). Review of the submitted information finds that the disputed services are related to a rehabilitative inpatient admission; therefore, the applicable rule for reimbursement is 28 Texas Administrative Code §134.1. Thus, a reimbursement amount that is calculated based upon the stop-loss methodology found in §134.401(c)(6) cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
- Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit any medical documentation to support the disputed services as billed.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and

reasonable rate of reimbursement for the services in this dispute.

- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	<u>Grayson Richardson</u> Medical Fee Dispute Resolution Officer	<u>December 27, 2012</u> Date
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_____ Signature	_____ Director, Health Care Business Management	_____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.